Reports must be sent to the New York State Department of Health within 10 days of diagnosis (State Sanitary Code, Part 22.4)

Occupational Lung Disease Registry
Physician Reporting Form

New York State Department of Health
Bureau of Occupational Health

Confidential Case Report

Type or print clearly using blue or black ink.

Date of Report __ __ /__ __ / __ __ __ __

Patient Information:

Last Name	First	MI

Address Street	City	State	Zip Code	FIPS

Home Phone Number	Date of Birth	Gender	Social Security Number
( )	__ __ /__ __ / __ __ __ __	❑ Male ❑ Female	__ __ __ / __ __ / __ __ __ __

Race					Hispanic
❑ White	❑ Black/ African American	❑ American Indian/ Alaskan Eskimo	❑ Asian/ Pacific Islander	❑ Other	❑Yes ❑ No

Employer (company name) at Time of Suspected Exposure	Suspected Relevant Occupation	COC Code

Suspected Diagnosis	Confirmed	Suspected	Date of Diagnosis	Suspected Agent	AOEC
❑ Occupational Asthma	❑	❑	__ /___ /_____		
❑ Reactive Airways Dysfunction	❑	❑	__ /___ /_____		
❑ Hypersensitivity Pneumonitis	❑	❑	__ /___ /_____		
❑ Farmers Lung Disease	❑	❑	__ /___ /_____		
❑ Bird Handlers Lung Disease	❑	❑	/ /		
❑ Inhalation Fevers	❑	❑	__ /___ /_____		
❑ Metal Fume Fever	❑	❑	__ /___ /_____		
❑ Polymer Fume Fever	❑	❑	__ /___ /_____		
❑ Organic Dust Toxic Syndrome	❑	❑	/ /		
❑ Toxic Irritant (e.g. smoke, chlorine, gas, etc.)	❑	❑	__ /___ /_____		
❑ Silo Filler's Lung Disease	❑	❑	__ /___ /_____		
❑ Metal-Induced Disease	❑	❑	__ /___ /_____		
❑ Berylliosis	❑	❑	__ /___ /_____		
❑ Hard Metal Disease	❑	❑	__ /___ /_____		
❑ Pneumoconiosis	❑	❑	__ /___ /_____		
❑ Asbestosis	❑	❑	__ /___ /_____		
❑ Byssinosis	❑	❑	__ /___ /_____		
❑ Coal Workers Lung Disease	❑	❑	__ /___ /_____		
❑ Silicosis	❑	❑	__ /___ /_____		
❑ Pleural Disorders	❑	❑	__ /___ /_____		
❑ Asbestos-related Pleural Plaques	❑	❑	__ /___ /_____		
❑ Mesothelioma	❑	❑	__ /___ /_____		
❑ Pulmonary Fibrosis, Undet. Etiology	❑	❑	__ /___ /_____		
❑ Chronic Bronchitis	❑	❑	/ /		
❑ Lung Cancer	❑	❑	__ /___ /_____		
❑ Other,	❑	❑	__ /___ /_____		

Related Diagnostic Test Performed	Test Results Normal	Abnormal	Pending	Date of Test	Location Where Performed Name	Address
❑ Pulmonary Function Test	❑	❑	❑	___ /___ /_____		
❑ Peak Flow	❑	❑	❑	___ /___ /_____		
❑ Challenge Test	❑	❑	❑	___ /___ /_____		
❑ Bronchoscopy	❑	❑	❑	___ /___ /_____		
❑ X-ray	❑	❑	❑	___ /___ /_____		
❑ CT Scan	❑	❑	❑	___ /___ /_____		
❑ Serology	❑	❑	❑	___ /___ /_____		
❑ Cytology	❑	❑	❑	___ /___ /_____		
❑ Allergy Testing	❑	❑	❑	___ /___ /_____		
❑ Lung Biopsy	❑	❑	❑	___ /___ /_____		
❑ Other, _____	❑	❑	❑	___ /___ /_____		

Reporting Physician:

Name	City	State	Zip	Phone
				( )

Case is non-occupational ❑

Comments:

To request additional forms please check the box below and indicate how many forms are needed or visit http://www.health.state.ny.us/nysdoh/lung/lung.htm to download the form.

☐ _____

You may also report an occupational lung disease by calling toll free 1-866-807-2130.

Please send/fax completed form to:

New York State Department of Health
Bureau of Occupational Health
Occupational Lung Disease Registry
Flanigan Square, Room 230
547 River Street
Troy, New York 12180-2216

Fax: (518) 402-7909